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ABSTRACT

The National Goals 2000 emphasizes the importance of public school children's socio-emotional and physical health. Twenty percent of America's public school children suffer significant mental health problems. The longer schools wait to intervene with children at risk, the more expensive and less successful the schools' efforts will be. Aggressive or withdrawn preschoolers may later experience academic difficulties, troubles with friendships and authority, and perhaps even fall into delinquency. Successful early intervention programs incorporate three components: (1) early diagnostic evaluations to identify children at risk; (2) services which support children's physical health and mental health; and (3) parent education and involvement. School psychologists, in particular, should devote special attention to literacy, the mental health needs of the gifted, services for school-aged parents, and school mental health and home school partnerships. Comprehensive systems for addressing students' social and emotional needs are imperative in order to increase school retention and to facilitate learning. These systems must be tailored to the various schools and communities and should include broad preventative measures which pervade the general school climate. School psychologists and other school mental health professionals are uniquely trained to participate in the planning and implementation of these programs which bring together schools, families, and communities. (Contains 96 references.) (RJM)

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WHY SCHOOL MENTAL HEALTH IS ESSENTIAL FOR REFORMED SCHOOLS

A report of
Division 16's Committee on Children Youth and Families
American Psychological Association

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In 1991, the America 2000 National Education Goals (now retitled National Goals 2000) set a national agenda for public school reform. Included were goals stating that every student should begin school ready to learn, that ninety percent of public school students should graduate from high school, that students demonstrate competence in all major scholastic subjects, that every adult American be literate, that students in our schools lead the world in their mastery of science and mathematics, and that our schools be free of drugs and violence. These goals reveal a shared urgency about public schools' ability to prepare students for the 21st century and a national commitment to education as a foundation for citizenship. Moreover, these goals transcend the traditional focus of educational reform efforts on scholastic performance by also proclaiming the critical importance of children's socio-emotional and physical health. As school psychologists, we applaud the emerging recognition of students' social and emotional health and are encouraged by the growing emphasis on education as a source of personal success. At the same time, we are very aware that public schools are in crisis because the nation's children are in crisis, and efforts to create healthy schools must, necessarily, include efforts towards supporting social and emotional adjustment. We believe our contributions and those of the other school mental health professions are essential for the success of reformed schools.

THE MENTAL HEALTH OF AMERICA'S CHILDREN

One out of every five students in America's public schools has significant mental health needs (Costello, 1989; Offord, Boyle, Fleming, Blum, & Grant, 1989; Velez, Johnson, & Cohen, 1989). They live with emotional distress that is painful, that threatens their life-success, that diminishes their contributions to families and communities, and that leaves them unavailable for learning. Consider a typical elementary school of 1,000 students. Recent epidemiological research tells us that:

** 42 of these students have serious conduct disorders: one student in every classroom (Offord, Boyle, Fleming, Blum & Grant, 1989). The aggressive and non-compliant behavior of conduct disordered students seriously disrupts the learning of every student in the class. Related difficulties with friendships, following rules, and obeying authorities places these students at risk for not graduating and not succeeding vocationally.

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** Some of these conduct-disordered students are also included among the 64 students in this hypothetical school with attention deficits (Szatmari, Offord, & Boyle, 1989). They are fidgety, impulsive students who are frequently overactive and have difficulty focusing their attention on scholastic tasks for long enough to learn efficiently. The difficult behaviors of students with attention deficit disorders make them frequent targets of adult irritation and children's intolerance, and as a result, they often develop very low self-esteem and are socially awkward. These children are also at risk for dropping out.

** Over 180 children in this school are likely to have serious anxiety disorders (Benjamin, Costello, & Warren, 1990; Kashani & Orvaschel, 1990). These include children with phobic reactions that prevent them from making friends or taking tests, or even prevent them from talking out loud or coming to school at all. Other children struggle with excessive worries, or with physical symptoms of stress and anxiety.

** Between 8 and 14 students struggle with clinical depression (Costello et al., 1988; Kaplin, Honig, & Weinhold, 1984; Kashani, Carlson, & Beck, 1987; Kashani et al., 1983). Adults will notice that these depressed students are lethargic or irritable, and may notice disturbances in sleep and eating. Even sensitive adults may not sense the profound misery that depressed students struggle with and their pervading sense of worthlessness.

If instead our typical school were a middle or high school, the picture would shift somewhat. Studies lead us to expect almost twice as many conduct disordered adolescents (Offord, et al., 1989), slightly fewer teens with attention deficits (Szatmari, Offord, & Boyle, 1989), and just as many students with anxiety disorders, although anxious adolescents worry about different things than younger children. Rates of depression soar in adolescence and 57 of 1,000 secondary students are likely to be clinically depressed (Kashani, Rosenberg & Reid, 1989). Moreover, adolescence brings with it some new and life-threatening mental health concerns including eating disorders (34 out of 1,000 girls; Stein & Brinza, 1989) and suicide attempts (85 out of 1,000 students; Joffe, Offord, & Boyle, 1988). A typical high school of 1,000 students is likely to have a completed suicide every ten years (Center for Disease Control, 1987; Cheifetz et al., 1988).

If other community agencies were addressing the social and emotional needs of these youth, schools might be able to concentrate their efforts on their students' scholastic performance. Instead, only 3% of school-aged children and youth actually receive mental health services from public or private providers in the community, leaving a 17% gap between the number needing and the number receiving services (Knitzer, 1990). Schools can't accommodate to the unique needs of these students without the special knowledge and services of school mental health professionals.

WHY CHILDREN WITH MENTAL HEALTH NEEDS MUST BE IDENTIFIED EARLY

The longer we wait to pick out and intervene with children at risk, the more expensive and less successful our efforts will be. Preschoolers who are aggressive,

withdrawn, or have poor language skills are likely to be academically unsuccessful in school, to have difficulties with friendships and adult authorities, and sometimes to struggle with delinquency in adolescence (Schweinhart, Weikart, & Larner, 1986; Tremblay et al., 1992). Early childhood interventions have been successful in preventing later learning and development problems with children exposed to drugs prenatally (Johnson, 1993; Rist, 1990); children with delayed physical, emotional or cognitive development (Greenspan, 1981; Lombardi, 1990); and children with language delays (Hinshaw, 1992). Longitudinal studies have shown significant academic, social and emotional gains for children in these programs (Flynn, 1993; Geddes, 1992, Lombardi, 1990; Ogilvy, 1992; Schweinhart et al., 1986; Tremblay et al., 1992). Without early intervention, some children experience overwhelming difficulties and even death (Dichtelmiller et al., 1992; Rist, 1990; Wilson, Mitchell, Rolnick & Fish, 1993).

Successful early intervention programs incorporate three components: (1) Early diagnostic evaluations to identify children at risk (Bagnato, Neisworth, Paget & Kovaleski, 1987; Bracken, 1987; Lidz, 1983, 1991; & Meisels, 1989); (2) Nutritional counseling or other services supporting children's physical health, and developmental counseling supporting children's emotional needs (Dichtelmiller et al., 1992; Rist, 1990; Wilson, Mitchell, Rolnick & Fish, 1993); and (3) Parent education and involvement (Flynn, 1993; Greenspan & Porges, 1984; Johnson, 1993; Lombardi, 1990; Molfese et al., 1993; Rist, 1990; Wilson et al., 1993). School mental health professionals sustain these early intervention efforts by supporting professional, multidisciplinary teams (Hinshaw, 1992; Kendall, Lerner, & Craighead, 1984; Lowenthal, 1992; Miller, 1991; Paget, 1985), contributing developmental knowledge and diagnostic expertise to team efforts (Geddes, 1992; Lidz, 1991; Leavitt & Eaheart, 1991; Ysseldyke et al., 1983), coordinating multiple sources of information from within the school and from outside agencies (Bagnato et al., 1987; Kagan, 1992; NAEYC, 1991; Taylor, Willets, & Lieberman, 1990); and participating in the development and modification of educational plans.

LINKS BETWEEN MENTAL HEALTH AND LITERACY

Concern with the development of literacy is central to many school reform efforts. Literacy is the ability to understand and create written language and is essential for effective participation in our communities. Illiteracy is increasingly associated with maladaptive behavior and distress in adulthood (Kozol, 1985; Sollod, 1987). Current conceptions of literacy emphasize its gradual emergence from social communication processes (Teale & Sulzby, 1986). Very early parent-child interactions around book reading play an important role in the acquisition of language and an understanding of books and words (Ninio & Bruner, 1978; Snow, 1983; Snow & Ninio, 1986). Such experiences are not present to the same degree in all homes (Feagans & Farran, 1982; Heath, 1983; Ogbu, 1987). In addition, the quality of the relationship between caretaker and child may detract from the child's ability to explore and engage in literate actions (Bus & van Ijzendoorn, 1988). Hence some children come to school with less experience and are at greater risk for failure on traditional literacy tasks introduced in school. These new models of emergent literacy suggest that, if children are to find literacy to be personally meaningful, schools must understand the social-cultural context from which the children come, the patterns of communication within children's families, and parental expectations for children's literate actions. Thus literacy becomes a collaborative challenge for teachers

and school mental health professionals to engage in more holistic ways of assessing and supporting children and their families.

Once children experience failure in school an extremely negative and self-defeating cycle can emerge. Through failure experiences, children can develop a learned helplessness response -- beliefs about themselves as learners that tend to preclude constructive problem solving actions (Dweck & Leggett, 1988; Seligman, 1975; Wood, 1991). Believing themselves to have little control over their success or failure on literacy tasks, they give up easily, attribute any success to luck or ease of the task, and attribute failure to stable inadequacies in themselves (Thomas, 1979; Butkowski & Willows, 1980). In contrast to such a self-defeating cycle, children who believe that they have control over their learning persist in the face of challenge, viewing effort as significant to their eventual success on tasks (Dweck & Leggett, 1988).

Research documents the efficacy of comprehensive early intervention and prevention programs for students at scholastic risk and establishes that intervention is more difficult once a failure pattern is established (McCormick, Kerr, Mason, & Gruendel, 1992; Neuman & Roskos, 1993; Pinnell, 1989; Slavin, Madden, Karweit, Livermon, & Dolan, 1990). Successful programs provide (a) intensive one-on-one instruction for at risk students early in their school careers, (b) frequent and systematic assessment of learning progress, (c) flexible and responsive curriculum planning and implementation, and (d) teacher support and inservice programs. Finally, effective programs are sensitive to the personal beliefs of students and the parental attitudes and expectations that might foster constructive belief systems (Ames and Archer, 1987). School mental health professionals make vital contributions to literacy programs by working with children' and parents' self-defeating beliefs and attitudes towards literacy and learning (Wood, 1991; 1992).

WHY MENTAL HEALTH NEEDS OF THE GIFTED ARE CRITICAL TO COMPETITIVENESS

If we are to remain competitive with other industrialized countries, school reform efforts must consider scholastic and social-emotional needs of intellectually gifted students and those who show exceptional skills in reasoning, scholastic subjects, leadership, creativity and the arts. In particular, educators must confront the myth that the gifted and talented put forth little effort and need no special programming in order to be successful (Colangelo & Davis, 1991; DeLeon & VandenBos, 1985). As a second and related concern, identification procedures are frequently invalid, discriminatory, and used inappropriately. This leads to the over identification of conforming, high-achieving white middle-class students and to under identification of minority students, those with specific abilities, the handicapped gifted, underachieving gifted, creative and divergent thinkers, and those who exhibit negative behaviors such as boredom with routine work and disagreement with teachers (Richert, 1991). While most gifted and talented students are socially competent, a subset of highly gifted students are especially at risk because they are socially isolated and awkward, and struggle with profound feelings of worthlessness. These students need the assistance of a mental health professional to reflect upon their personal life goals and arrive at a more authentic and accurate understanding of their personal worth.

WHY SERVICES FOR SCHOOL-AGED PARENTS ARE DOUBLY IMPORTANT

Significant numbers of students in schools are themselves parents, and schools provide an accessible, cost-effective setting within which these parents can be educated to provide effective parenting to the next generation of children at risk. In the United States, 83% of males and 74% of females engage in sexual intercourse before leaving their teen years (Santrock, 1993). This represents a significant increase over the 1970's (Joshi, 1990; Santrock, 1993; Voydanoff & Donnelly, 1990). Because American youth either do not use contraceptives or use them ineffectively, pregnancy rates in the United States are the highest in the industrialized world (Jorgensen, 1993; Santrock, 1993). Statistics from the National Center for Health Statistics (1988) indicate that in 1986, one in twenty teenage girls gave birth. Despite popular perceptions, this isn't necessarily a problem of poor minority youth. Black teens represent a disproportionately large 30% of teens giving birth only because white teens are more likely to end their pregnancies in abortion (Adams, 1989).

Leaving school is only one of the social and economic costs of having a child during adolescence. Early childbearing is also linked to lowered self-esteem and self-efficacy, lower work status, increased risk of child abuse, strained family relationships and psychological distress and depression (Jorgensen, 1993; National Research Council, 1987; Rickel, 1989; Santrock, 1993; Voydanoff & Donnelly, 1990). Health-related risks of early pregnancy include pregnancy complications such as toxemia, anemia, prolonged and premature labor, higher maternal death rates, and excessive weight gain in mothers (National Research Council, 1987; Voydanoff & Donnelly, 1990). While not rigorously documented, some evidence suggests that pregnant teens are at increased risk for physical and sexual abuse, sexually transmitted diseases, and abuse of tobacco, alcohol and other substances (Berenson, San Miguel, & Wilkinson, 1992; Hussel, Gilchrist, Gillmore, & Lohr, 1992; Lohr, Gillmore, Gilchrist & Butler, 1992). This last is of special concern since fetal alcohol syndrome has been recognized as one of the more prevalent causes of preventable retardation in American children (Clarren, 1981). Girls who use substances during their pregnancy may be creating the next generation of children with disabilities.

Other psychological and health risks are passed on to children of teen-age parents. There is a greater likelihood that children born to teens will be born with low birth weight, spinal and head injuries, vision and hearing impairments, other physiological abnormalities, lower cognitive ability, or will die (Voydanoff & Donnelly, 1990). Many of these are preventable disabilities but, for various personal and bureaucratic reasons, half of all pregnant teens receive no prenatal care (Voyandoff & Donnelly, 1990). Given their medical risk, and the psychological risk of growing up with a teen age parent, children of adolescents are more likely to have social and behavioral difficulties at home and school, to have developmental delays including lowered cognitive abilities, to be physically and/or emotionally abused, and to experience trouble learning in school (Gullotta, Adams & Montemayor, 1993; National Research Council, 1987; Voydanoff & Donnelly, 1990). They, in turn, are more likely to become teenage parents themselves and to perpetuate the cycle of social, emotional, and scholastic maladjustment with their children.

Programs that break the cycle of children raising children focus on parent training for adolescent mothers including knowledge about what's normal in child development and

ways to enhance the cognitive and social skills of children (Clewell, Brooks-Gunn & Benasich, 1989; National Research Council, 1987). Some programs also include parent training for adolescent fathers (National Research Council, 1987; Rickel, 1989). Secondly, comprehensive programs for teenage parents provide for the continuation of education, job skills training, and life skills planning (including avoiding repeat pregnancies; National Research Council, 1987). Support services such as child care and income support are necessary if adolescents are realistically able to remain in school (Clewell, 1989). Finally, counseling services to keep teen parents focused on education and provide for alternative school schedules are effective in school retention (National Research Council, 1987). One school-based program in St. Paul, Minnesota was able to reduce pregnancy rates from 79 to 26 per 1,000 within ten years.

Alternatively, proactive programs can address teenage sexuality before accidental pregnancies occur by educating students about values surrounding sexuality, sexual responsibility, and developmentally appropriate information about contraceptive use and availability (Blau & Gullotta, 1993; Gibson, 1986; Maddock, 1989; Warren, 1992). Preventive programming is equally as important as programs for teen parents (Jorgenson, 1993). Broad-based program that increase academic skills, school retention, decision-making, problem-solving, social responsibility, job skill training and availability of jobs, life skills training and decrease substance abuse would most likely increase adolescents' motivation to delay childbearing.

SCHOOL MENTAL HEALTH AND THE HOME SCHOOL PARTNERSHIPS

Up to two thirds of the variance in student achievement has been accounted for by home rather than school variables (Coleman et al., 1966; Mosteller & Moynihan, 1972), making home-school partnerships key components of school reform. Students whose parents are heavily involved in their school show higher academic achievement (Hayes, Comer & Hamilton-Lee, 1989), better school attendance (Hayes et al., 1987), a more positive attitude towards school (Becher, 1984; Henderson, Marburger, & Ooms, 1986; Leler, 1983), complete more homework (Rich, 1988), earn better grades (Henderson et al., 1986), and have higher educational aspirations (McDill, Rigsby & Meyers, 1969). Parents who are involved are more satisfied with their student's teachers (Epstein, 1984; Rich, 1988) and see the classroom and school climate as more positive and helpful (Hayes et al., 1989).

While parent involvement varies dramatically from school to school, comprehensive parent involvement programs provide multiple options for parents to give as well as receive services. Possible avenues for parent involvement that can benefit from services of school mental health professionals include parent volunteer programs supporting during and after-school programs for students; parent advisory groups in which parents are consulted regarding the logistical management of schools to address unique family and community needs; parent education programs that provide parents with additional instruction in essential parenting skills; and parents supporting parents programs that build communities of supports among parents sharing similar problems and histories. School mental health professionals have received training in child development, counseling, and family/school interventions and so are uniquely suited to support family/school partnerships.

WHY SCHOOL MENTAL HEALTH PROFESSIONS MUST PARTICIPATE IN SCHOOL REFORM INITIATIVES

These are some of the many ways in which students' social and emotional well-being is essential to their academic success, their subsequent employability and their future as competent citizens and parents. Comprehensive systems for addressing the needs of students' social and emotional needs are imperative in order to increase school retention and facilitate learning. These systems must be tailored to the issues of various schools and communities and should include broad preventative focuses that affect the general school climate as well as interventions for individual students. School psychologists and other school mental health professionals are uniquely trained to participate in the planning and implementation of these programs that bring together schools, families and communities in working towards achievement of the National Goals 2000.

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